STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 13,475

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Appeal of)

INTRODUCTION

The petitioner appeals the decision by the Department of Aging and Disabilities (hereinafter referred to as DAD or the Department) denying her application for services under the Home and Community Based Services Waiver Program (hereinafter referred to as the medicaid waiver program). The issues are whether the evidence establishes the petitioner's eligibility for the program and whether the Department in denying the petitioner's application violated the petitioner's due process rights and/or the Americans with Disabilities Act (ADA).

FINDINGS OF FACT

In lieu of an oral hearing the parties submitted this matter on the basis of written medical evidence, legal arguments, and the depositions of several DAD personnel. The following "factual background" is taken from the petitioner's memorandum, and does not appear to be in dispute.

[Petitioner] is a 49-year-old woman with a substantial number of severe health problems. She has been diagnosed with multiple personality disorder, panic disorder, and bipolar disorder, including a history of suicidal attempts. She also suffers from physical symptoms as a result of environmental sensitivities. She has hypoglycemia, anemia, and knee defects. Furthermore, these health problems cannot be treated by medications because [petitioner] is allergic to drugs of all kinds. [Petitioner] suffers from a phobic disorder which restricts her ability to go places. She cannot go anywhere alone, and requires a full-time attendant to do shopping, manage her finances, and pay her bills. [Petitioner] is extremely sensitive to chemicals and suffers from food allergies which require her attendant to plan and prepare special meals for her.

The only medical evidence submitted by the petitioner in support of her claim is the following letter, dated March 10, 1995, from her treating therapist, a licensed Ph.D. psychologist:

I have been working with [petitioner] in intensive therapy since October, 1993. I am writing this letter in order to state why I judge her to need attendant care in a home setting. Secondarily, I will state why I do not think she would do well in a psychiatric setting such as a group home. In the unfortunate event that she would have to be placed in a group facility (definitely not the best setting for her), I think that she would do much better in a nursing home than in a psychiatric group home.

I consider [petitioner] to need attendant care on a 24-hour-a-day basis because of her sudden and unpredictable shift in mood (from normal to manic to fearful and panicked and/or deeply depressed and suicidal) and, consequently, in her ability to care for herself (get meals, do household chores, leave the house to drive to obtain supplies, go to appointments, etc). These changes are associated with mood disorder. She had the diagnosis from DSM-IV of Bipolar I Disorder, last episode mixed, rapid cycling (296.6). Research on bipolar disorder suggests a strong biological component to its origins. Although many individuals with bipolar disorder are able to take medication which helps at least somewhat to stabilize their mood swings, [petitioner] has a history of dismal responses to medications--she has not been able to tolerate their effects on her body. She has, therefore, decided not to take psychiatric medications, and her environment is very important to helping her live through her mood shifts. Attendant care helps with providing some external stability, providing the safety of having another person present to help influence her by presence not to act on suicidal thoughts, and providing her daily living needs that [petitioner] cannot provide at all or consistently for herself.

A psychiatric group facility would be contraindicated because [petitioner] is agitated by actively agitated mentally disordered people (this has made necessary psychiatric hospitalizations very difficult and tumultuous). She also associates psychiatric facilities with being abused because of experiences in a state hospital in her early adult life. The loose structure of a group home would also not be optimal for [petitioner] during agitated periods for her.

A nursing home setting would be better than a psychiatric group home setting, if one of these became necessary. The group nature to the setting would still be difficult for [petitioner], but she feels comfortable with elderly people and tends to be less agitated by them than by psychiatric patients. The structure would also be somewhat greater in a nursing facility, and attention to her nutritional and other multiple physical needs would be immediately accessible.

In summary, I judge [petitioner] to need 24-hour attendant care in a home setting, due to her psychiatric and physical need and limitations. In the unfortunate event that she should ever have to be placed in a group facility, a nursing home would be much better suited to her needs than a psychiatric group home.

According to her Memorandum, the petitioner's application for medicaid waiver services has been through several layers of evaluation and review by the Department. An initial evaluation by an R.N. employed by the Visiting Nurses, who did a home visit with the petitioner at the Department's request, resulted in a recommendation that the petitioner was eligible for medicaid waiver services based on her need for daily supervision in dressing, bathing, and eating, and on her inability to live "safely independently".

The visiting nurses' R.N.'s recommendation was then reviewed by an R.N. employed by the Department's Division of Licensing and Protection, whose job includes reviewing applications for medicaid waiver services. This individual did not meet with the petitioner, basing her review solely on the findings of the visiting nurses' R.N. The Department's R.N. determined that the petitioner did not require "skilled nursing" services or supervision, and that, therefore, she was ineligible for medicaid waiver services.

At the petitioner's request, after her initial denial, the Department's R.N. reconsidered the petitioner's application. The R.N. reviewed the written statement (supra) from the petitioner's psychotherapist, but still determined that the petitioner was ineligible.

Subsequently, the Department assigned another R.N. to conduct a visit to the petitioner's home and make a redetermination of the petitioner's eligibility in light of her findings. This R.N. interviewed the petitioner and her caregiver and took written statements from them. Those statements were consistent with and elaborated somewhat on the letter (supra) from the petitioner's psychotherapist. Following her visit, this R.N. submitted a report that described the petitioner's situation as one of "complexity". The report concluded, however, "if we were looking at (petitioner) as we do nursing home admissions, she would probably be considered eligible for placement due to her inability to function independently and her mental status." Following its receipt of the above report the Department decided to submit the matter to a physician who regularly reviews "questionable" medicaid waiver decisions. The physician reviewed the written report of the second Department R.N. as well as the written statements of the petitioner, her caregiver, and her psychotherapist (supra) that had been part of the R.N.'s report. He concluded that the petitioner did not require the level of care provided by a "skilled" or "intermediate nursing care facility" in that her "principal problem and underlying cause for her disability is primarily psychopathology: bipolar disorder, periods of suicidal depression, and multiple personality disorder."

On the basis of the physician's opinion, the Department concluded as its final decision in the matter that the petitioner was ineligible for medicaid waiver services because her condition would not qualify her for admission into a skilled or intermediate nursing care facility.

The parties appear to agree that the factual issue in this matter is, indeed, whether the petitioner meets the criteria for admission to a "skilled" or "intermediate care facility". Although it appears that certain Department personnel have been less than articulate--and, at times, even contradictory--in describing the legal standards for the medicaid waiver program and the reasons the petitioner was denied, based on the record presented it cannot be concluded that the Department, as a matter of either practice or policy, discriminates against persons with mental handicaps in considering their eligibility for medicaid waiver services. Nor can it be concluded that the standards the Department uses for that program are so vague and unclear as to constitute a violation of the petitioner's due process rights. Under the Department's written guidelines (see infra) medical eligibility for medicaid waiver services is clearly predicated upon medical need for "nursing home" admission.

Based on the uncontroverted evidence presented by the petitioner, it must be found that the petitioner requires (as she, herself, describes it) "24-hour attendant care". The petitioner cannot safely be left alone for more than a few hours at a time, and she needs frequent emotional support and reminders regarding feeding, bathing, personal care, and home maintenance. She is also dependant on assistance for managing her finances and performing some chores, such as shopping, that are done outside the home.

The petitioner presented no medical evidence, however, that she requires nursing care. It does not appear that her present attendant/companion has any professional medical or nursing training--or that she (or someone else) should have it in order to perform her job more effectively. Nor is the petitioner's present care being provided under the supervision of a physician or nurse (indeed, there is no indication that the petitioner even has an attending physician). The petitioner does not require any direct or "hands-on" assistance with feeding, bathing, personal care, or household chores. Therefore, it cannot be concluded that the petitioner requires the level of care provided by a "nursing facility" as defined and contemplated by federal and state law (see infra).

The petitioner has also not established that "attendant care" would not be available to or suitable for her in a setting other than in a nursing home. Other than the petitioner's limited experience with psychiatric facilities and her apparent preconceptions regarding group homes, and her psychotherapist's inexpert and

wholly unsupported opinion that the petitioner would be "better off in a nursing home than in a psychiatric group home", there is no evidence that there do not exist suitable alternatives that could provide the type of attendant care the petitioner requires.

ORDER

The Department's decision is affirmed.

REASONS

Under the federal Social Security Act states have the option of submitting a "waiver" to use federal Medicaid funds to provide "home and community based services" to individuals who:

would be eligible under the State Plan . . . if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services . . . they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State Plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary. . . .

42 U.S.C. § 1396a(a)(10)(A)(ii)(VI). Thus, states may offer medicaid waiver services to an individual medicaid recipient if it can be established that were it not for the provision of such services the individual would require the level of care provided in a hospital or nursing facility (or, in the case of a mentally retarded individual, in an "intermediate care facility" especially designed for that purpose). Vermont has chosen to exercise this option, and since 1987 has provided home and community based services under its medicaid waiver program.

Section M901 of the Vermont medicaid regulations defines which types of "long-term care facilities" are eligible for medicaid coverage. This section divides such covered facilities into three categories: skilled nursing facilities (SNF), intermediate care facilities (ICF), and intermediate care facilities for the mentally retarded (ICF-MR). SNF care is also covered by Medicare, and is primarily short-term and rehabilitative in nature.(1) ICF care is basic long-term nursing home care. The parties in this matter appear to agree that the criteria for medicaid waiver eligibility is whether the petitioner qualifies for ICF, or nursing home, care.

In Vermont, the difference between a "nursing home" and other types of "residential care home" is defined by statute. 33 V.S.A. § 7102 includes the following provisions:

The following words and phrases, as used in this chapter, have the following meanings unless otherwise provided:

(1) "Residential care home" means a place, however named, excluding a licensed foster home, which provides, for profit or otherwise, room, board and personal care to three or more residents unrelated to the home operator. Residential care homes shall be divided into two groups, depending upon the level of care they provide, as follows:

(A) Level III, which provides personal care, defined as assistance with meals, dressing, movement, bathing, grooming, or other personal needs, or general supervision of physical or mental well-being,

including nursing overview and medication management as defined by the licensing agency by rule, but not full-time nursing care; and

(B) Level IV, which provides personal care, as described in subdivision (A), or general supervision of the physical or mental well-being of residents, including medication management as defined by the licensing agency by rule, but not other nursing care;

* * *

(7) "Nursing home" means an institution or distinct part of an institution which is primarily engaged in providing to its residents any of the following:

(A) Skilled nursing care and related services for residents who require medical or nursing care.

(B) Rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

(C) On a 24-hour basis, health related care and services to individuals who because of their mental or physical condition require care and services which can be made available to them only through institutional care. . . .

Of the above categories only "nursing home" care is covered by medicaid. See Medicaid Manual §§ M900 et. seq. In this case, that distinction is crucial. The federal medicaid waiver statute (supra) is clear that it is meant to cover only those individuals (except the mentally retarded) who qualify for the services of a hospital or "nursing facility"--i.e., those facilities whose services qualify for medicaid coverage. This distinction is also made clear in the Department's written guidelines for home and community based waiver services, which begin with the following provisions:

BACKGROUND

State assurances under the waiver require that the state will provide for an evaluation and periodic re-evaluations of the waiver client's need for the level of care provided in an intermediate care facility.

SUMMARY

The level of care determination is performed by registered nurses employed by the department of Health. (sic) Division of Medical Care Regulation following the utilization review elements used in determining intermediate care needs of nursing home patients. Reviews are required at the time of the initial plan of care development and at least every 6 months thereafter, coinciding with the reassessment (see Waivered Service Administration).

DEFINITION

Intermediate care is the provision of services for persons whose health needs require medical and nursing supervision or care. Patient's have Physical and/or mental and/or social dysfunction requiring substantial assistance with personal care needs involving activities of daily living such as bathing, dressing, and mobility. The determination of a client's level of care is a professional decision based on

the functional capacity of the individual and his/her nursing needs.

In Vermont Intermediate Care is also referred to as Level II or ICF care. These terms will be used interchangeably throughout this document. . . .

As noted above, although the evidence clearly establishes that she requires 24-hour "attendant care", there is no evidence that the petitioner requires nursing care--or even nursing "overview".(2) There is no evidence that the petitioner would not function as well or better in a group home that houses primarily elderly (but otherwise healthy) individuals than in a nursing home with a significant number of severely disabled (and demented) elderly persons--and that such an option would not be available to her. As noted above, other than the petitioner's own limited experiences and preconceptions, and her psychotherapist's unsupported opinion that the petitioner would "do much better in a nursing home than in a psychiatric group home" there is no evidence that the petitioner's options are so limited. In fact, except for emotional support and environmental concerns (which would probably be even more problematic in a nursing home than in a Level III or IV facility), the level of care required by the petitioner, as described by her and her caregivers, fits much more closely under the definitions of "Level III" and "Level IV" care than it does under "nursing home" care as defined in 33 V.S.A. §§ 7102(1)(A), (1)(B), and (7), supra. Unfortunately, this level of care is not covered by medicaid, and, therefore, cannot be covered by medicaid waiver services.

Even if it could be found that the petitioner's condition would make living in most Level III or IV group homes unsuitable, it cannot be concluded that she must qualify for nursing home care--and, by extension, for medicaid waiver services--under a theory of "default". At worst, the petitioner's perceived predicament points up the fact that there indeed may be limited residential options for individuals with her unique medical needs. This lack of options, however, even if it could be shown to exist, does not, in and of itself, qualify the petitioner (or anyone else) for "nursing home" care.

Because the petitioner cannot show that she requires nursing home care, in determining whether she has been discriminated against in the medicaid waiver program she cannot be considered a "qualified individual with a disability" as required by the ADA. 42 U.S.C. § 12130. The petitioner would, thus, be forced to argue that the state discriminates against persons with mental disabilities in determining their eligibility for nursing home admission. The petitioner does not make this argument; and, even if she did, it is not supported by any evidence.

Absent medical evidence that the petitioner requires care that can only be provided in an "intermediate care" nursing facility, it cannot be concluded either that she qualifies for medicaid waiver services or that she has been discriminated against in her application for those services. The Department's decision is, therefore, affirmed.

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1. Although neither party addressed this issue, the hearing officer is informed that in Vermont several hospitals and nursing homes (ICFs) maintain separate SNF facilities to treat patients who are eligible under Medicare for such services.

2. "Nursing care" is defined in 33 V.S.A. § 7102(7) as follows:

"Nursing care" means the performance of services necessary in caring for the sick or injured that require specialized knowledge, judgment and skill and meet the standards of the nursing regimen, or the medical regimen, or both, as defined in 26 V.S.A. § 1572(4) and (5). . . .